

Report
of the
Examination of
Medical Associates Clinic Health Plan of Wisconsin
Dubuque, Iowa
As of December 31, 2004

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

August 26, 2005

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Honorable Jorge Gomez
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of
the affairs and financial condition of:

MEDICAL ASSOCIATES CLINIC HEALTH PLAN OF WISCONSIN
Dubuque, Iowa

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Medical Associates Clinic Health Plan of Wisconsin (the company) was conducted in 2002 as of December 31, 2001. The current examination covered the intervening period ending December 31, 2004, and included a review of such 2005 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the company's operations and included the following areas:

- History
- Management and Control
- Corporate Records
- Conflict of Interest
- Fidelity Bonds and Other Insurance
- Provider Contracts
- Territory and Plan of Operations
- Affiliated Companies
- Growth of the Company
- Reinsurance
- Financial Statements
- Accounts and Records
- Data Processing

Emphasis was placed on the audit of those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the company's operations is contained in the examination work papers.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Medical Associates Clinic Health Plan of Wisconsin is described as a nonprofit group model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the group model, the company contracts with a sponsoring clinic to provide primary and specialist services. HMOs compete with traditional fee-for-service health care delivery.

The company was incorporated on October 25, 1983, and commenced business on January 1, 1985. The company is controlled by Medical Associates Clinic, P.C., (the Clinic) the HMO's sponsoring clinic and founder.

The HMO contracts with the Medical Associates Clinic, P.C., to provide primary and specialty care to its members. These services are provided to the HMO's members through physicians at the Clinic. The Clinic also contracts with individual physicians to provide services to members who reside in other parts of the HMO's service area. The Clinic receives a per-member, per-month capitation payment to provide services to the members of the HMO. This capitation payment transfers the risk to the Clinic. However, the HMO also has an agreement with the Clinic under which the HMO retains 90% of the amount of non-Medicare claims for inpatient hospital services between \$10,000 and \$85,000 per enrollee, per contract year.

The provider network for the HMO consists of 83 primary care physicians and 103 specialty care physicians providing care on a 24-hour basis. Members are expected to select a primary care physician. However, members may go to any physician on the provider list, including specialists, unless otherwise noted on the provider list (physicians who are referral only are noted as such). If the member has to see a physician outside of the HMO's network, an authorized referral is needed. In many instances the referring physician will obtain the referral for the subscriber. However, it is the subscriber's responsibility to ensure a referral is obtained. The HMO currently contracts with the following clinics:

Bluff Street Clinic
Boscobel Clinic S.C.
Dodgeville Medical Center
Family Medicine Associates
Grant Regional Health
Lancaster Family Medical Center
Manchester Family Medical Associates
Maski & Maski
Medical Associates Clinic of Darlington
Mineral Point Medical Center
Potosi-Tennyson Medical Center
Strawberry Point Medical Center
Women's Wellness Center

The provider contracts include hold-harmless provisions for the protection of policyholders stating that the "Medical Care Provider, or his/her, or its assignee or subcontractor hereby agrees that in no event, including but not limited to non-payment by the Medical Associates or Medical Associates' insolvency or breach of this agreement, shall Medical Care Provider or his/her, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person or Persons, other than Medical Associates." Physicians agree to accept as payment in full the lesser of billed charges or the maximum allowable fee schedule set by Medical Associates for services. The contract does not include any "withhold" provisions as part of the compensation structure. Physicians also agree not to bill the patient for any services which Medical Associates has determined not to be "medically necessary." The contract became effective July 18, 1988, and may be terminated without cause by either party with 90 days notice. Termination with cause can occur after 30 days prior written notice if the cause for termination has not been remedied. Termination of the contract does not release the physician from his or her obligations to the patient.

The HMO contracts with 15 hospitals to provide inpatient services. Hospitals are reimbursed on a negotiated per diem basis. The contracts include hold-harmless provisions for the protection of policyholders.

The following is a listing of hospitals the HMO contracts with:

Boscobel Area Health Care
Central Community Hospital
Finley Hospital
Galena Stauss Hospital
Grant Regional Health Center
Guttenberg Municipal Hospital
Jackson County Public Hospital
Jones Regional Medical Center
Mercy Medical Center - Dubuque
Mercy Medical Center Dyersville
Memorial Hospital of LaFayette County
Prairie du Chien Memorial Hospital
Regional Medical Center of NE IA & Delaware Co.
Southwest Health Center
Upland Hills Health

Enrollees who require additional care which they are unable to receive at the contracting hospitals or those who require transplants can be transferred to other tertiary centers.

According to its business plan, the HMO's service area is comprised of the following counties: Crawford, Grant, Iowa and Lafayette.

The HMO offers comprehensive health care coverage, subject to riders for deductibles and copayments. The following basic health care coverages are provided:

Physician services
Inpatient services
Outpatient services
Mental health, drug, and alcohol abuse services
Ambulance services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Preventive health services
Family planning
Hearing exams
Diabetes treatment
Routine eye examinations
Convalescent nursing home service
Prescription drugs
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Physical fitness or health education (\$30.00 per year maximum)
Kidney disease treatment
Certain transplants
Chiropractic services

Inpatient mental health and alcohol and other drug abuse (AODA) coverage is limited to 30 days and \$6,300. Additional eligible inpatient expenses, up to a maximum of 30 days, are

payable at 50% of charges. Outpatient mental health and AODA coverage is limited to \$1,800 per year or 20 visits, whichever is greater. Emergency services have a \$75 copayment which is waived upon admission into an inpatient facility. Skilled nursing care is limited to 60 days. All mental health and AODA services except emergencies require precertification prior to receiving treatment, or the charges will be denied. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. The company also has various benefit plans in which inpatient services have copayments or deductibles subject to various out-of-pocket maximums.

The company currently markets to groups for non-Medicare coverage and individuals for Medicare supplement coverage. The HMO uses outside agencies and pays a commission on new and renewal business. Commission payments for new business are as follows:

Small Groups (2-50)	Percentage
1 st Five Groups	7%
6+ Groups**	9

** 2% bonus paid on 1st five groups after the 6th group is enrolled. This is a one-time bonus. A group must have a minimum of five employees enrolled to qualify. The maximum bonus per group is limited to \$2,000.

Commission payments for renewal business are as follows:

Small Groups (2-50)	Percentage
1 st \$200,000	4 %
\$200,000 plus	1.5

Commission payments for large groups, both new and renewal business are as follows:

Large Groups (50+)	Percentage
1 st \$200,000	4 %
\$200,000 plus	1.5

Commissions for Medicare supplement policies are 15% based on premium paid per member per month.

The company uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, coverage characteristics, and health histories or claims experience for new groups. Experience is reviewed for renewal

groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group. This only applies to large groups. The base rate is adjusted quarterly for inflation and other trending factors.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors currently consists of ten members. Three or four directors are elected annually to serve a three-year term. Officers are appointed by the board of directors for a one-year term at the board's annual meeting. The HMO's board of directors is identical to the board of Medical Associates Health Plan, Inc., the Iowa HMO described in the "Affiliated Companies" section of this report. The non-physician board members currently receive \$300, and clinic physician board members receive \$100 for each board or committee meeting attended, except for the executive committee meetings for which non-physician members receive \$200.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Chad Nachtman, M.D. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/06
Mark Janes, M.D. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/06
Jan Hess Dubuque, IA	Personnel Director (retired) Dubuque County Courthouse	3/31/06
Patrick Dillon Dubuque, IA	Manufacturing (retired) John Deere	3/31/07
Andrea Ries, M.D. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/07
Lawrence Kukla, M.D.. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/07
William Manzel, M.D.. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/08
Michael Scott, M.D. Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/08
Laurie Garms Dubuque, IA	Physician Medical Associates Clinic, P.C.	3/31/08
Joann Lueken Dubuque, IA	Personnel Director - Education Dubuque Community Schools	3/31/08

Officers of the Company

The officers appointed by the board of directors and serving at the time of this examination are as follows:

Name	Office	2004 Salary
Andrea Ries, M.D.	President	\$ 500
Mark Janes, M.D.	Vice President	900
Patrick Dillon	Secretary/Treasurer	2,700

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Executive Committee

Andrea Ries, M.D., Chair
Mark Janes, M.D.
Patrick Dillon

Investment Committee

William Manzel, M.D., Chair
Mark Janes, M.D.
Jan Hess

Audit Committee

Lawrence Kukla, M.D., Chair
Patrick Dillon
Laurie Garms, M.D.

Nominating Committee

Andrea Ries, M.D., Chair
Chad Nachtman, M.D.
Joann Leuken

Grievance Committee*

Board Members

Mark Janes, M.D.
Michael Scott, M.D.
Laurie Garms, M.D.
Andrea Ries, M.D.
Jan Hess
Joann Leuken
Patrick Dillon

Health Plan Members

Ann Knepper
Cindy Redmond
Sarah Hasken
Dave Robbins
Carole Reed

- * Per company bylaws, the grievance committee is to be composed of five persons; three health plan members, one member who is a physician director, and one member appointed from the board of directors. The committee members for a hearing are chosen from those listed above.

The HMO has no employees. Necessary staff is provided through a management agreement with Medical Associates Clinic, P.C. Under the agreement, effective August 1, 1996, the Clinic agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization review, and claims processing personnel; and provides or contracts for claims processing and MIS. The Clinic receives compensation for services rendered through the capitation arrangement paid

monthly based upon enrollment. The term of the agreement is continuous until voided by either party by written notice.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

Amount Required	
1. Minimum capital or permanent surplus	Either: \$750,000, if organized on or after July 1, 1989 or \$200,000, if organized prior to July 1, 1989
2. Compulsory surplus	The greater of \$750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3. Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each \$33 million of additional premiums earned in excess of \$10 million or 110% of compulsory surplus
4. Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;
2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2004 with a deposit of \$175,000 with the State Treasurer.

Insolvency Protection for Policyholders

Section Ins 9.04 (6), Wis. Adm. Code, requires HMOs to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

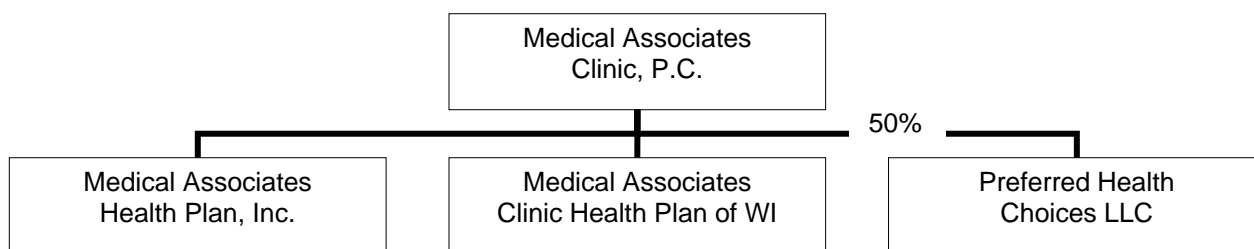
1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its reinsurance contract as discussed in the "Reinsurance" section of this report.

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is Medical Associates Clinic, P.C. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

Holding Company Chart
As of December 31, 2004



Medical Associates Clinic, P.C.

Medical Associates Clinic, P.C., is an Iowa professional service corporation operating as a private multi-specialty and family practice medical group. As of December 31, 2004, the company's audited financial statement reported assets of \$28,361,086, liabilities of \$12,368,692, and stockholders' equity of \$15,992,394. Operations for 2004 produced net income of \$4,475,852 on revenues of \$102,540,092.

Medical Associates Health Plan, Inc.

Medical Associates Health Plan, Inc., (MAHPI) is an Iowa incorporated company organized as a general for profit corporation for the purpose of providing comprehensive health care services. Medical Associates Health Plan of Wisconsin and MAHPI are operated by common management. As of December 31, 2004, the company's audited financial statement reported assets of \$17,300,820, liabilities of \$9,169,560, and capital and surplus of \$8,131,260. Operations for 2004 produced net income of \$1,877,668 on revenues of \$80,055,168.

Affiliated Agreements

The following provides a review of the affiliated agreements in effect at the time of the examination:

Administrative Service Agreement

Per an agreement with Medical Associates Health Plan, Inc., administrative expenses related to the operation of the two plans, such as the cost of management services, rent, utilities, postage, telephone, and all other customary and incidental expenses excluding direct expenses, shall be equitably allocated between the two HMOs based on the percentage of gross premium revenue of each plan to the total combined gross premium per month. Balances are settled on a monthly basis. The agreement also includes performance standards for administrative functions.

Service Agreement

The company has a service agreement with its sponsoring clinic, Medical Associates Clinic, P.C. The Clinic provides or arranges for all authorized medical services to all HMO enrollees through clinic physicians and participating hospitals and includes indemnification for services performed outside of the HMO's service area. The HMO pays the Clinic a monthly capitation for these services, with an annual adjustment. The agreement further provides that such compensation by the HMO represents full compensation for all medical and hospital services required by the HMO's enrollees. Per the agreement, the Clinic provides all the necessary personnel required for operation of the plan, and also provides the HMO with a medical director and chief executive officer.

Self-Insurance-Reinsurance Agreement

Under the terms of this risk-sharing agreement with the Clinic, the HMO indemnifies the Clinic for 90% of the amount of any claims for inpatient services provided by the Clinic to any non-Medicare enrollee which is in excess of \$10,000 up to a maximum of \$85,000 per member per year. The agreement also stipulates that the HMO will establish a reserve account to fund all such estimated claims. Per the agreement, the HMO is required to purchase, for the benefit of the Clinic, reinsurance which pays up to 90% of the amount paid by the Clinic for inpatient

hospital services provided to any non-Medicare enrollee which is in excess of \$85,000 for any contract year up to a maximum of \$2,000,000 in the enrollee's lifetime.

Reimbursement of Excess Centers for Medicare and Medicaid Services (CMS) Payments

The company agrees to reimburse Medical Associates Clinic, P.C., any payments made by CMS for previous underpayments of health care services provided by Medical Associates Clinic, P.C. The Clinic agrees to reimburse CMS and hold the company harmless for any excess CMS payments.

AMISYS System

The company owns certain hardware for a computer system referred to as the "AMISYS System" and its Iowa affiliate owns the software. Per an agreement between the affiliates, the cost of the system is equitably allocated based on the percentage of gross premium revenue HMO-Iowa and HMO-Wisconsin bears to the total combined gross premium revenue for each calendar month.

V. REINSURANCE AND CORPORATE INSURANCE

The company has reinsurance coverage under the contract outlined below:

Reinsurer:	Allianz Life Insurance Company of North America (Allianz Life)
Type:	Specific Excess of Loss Reinsurance
Effective date:	January 1, 2005
Retention:	Attachment point: \$85,000 per member per agreement year If a member undergoes a transplant in the Life Trac Network, his/her attachment point is \$75,000 for all eligible expenses in the contract year in which the transplant takes place.
Coverage:	Percentages payable: 90% Individual lifetime maximum: \$2,000,000
Premium:	Monthly premium per member: \$2.09
Termination:	Agreement terminates at the earliest of the following: <ol style="list-style-type: none">1. Nonpayment of premium2. The date of insolvency or cessation of operations of Allianz Life or Plan3. The date of a Material Change if Allianz Life notifies the Plan of termination for this reason within 30 days of Allianz Life being notified of the Material change4. The end of the Contract Year5. Upon the date of a material breach of this Agreement. The party terminating for this reason must give the other party notice of the actions or inactions which constitute the breach and five business days to cure the breach to the satisfaction of the notifying party.

The reinsurance policy has an endorsement containing the following insolvency provisions: The maximum aggregate amount paid by Allianz Life for insolvency coverage is \$5,000,000.

1. Allianz Life will continue plan benefits for members who are confined in a hospital on the date of insolvency and continue until the earlier of 365 days or the date of their discharge.
2. Allianz Life will continue plan benefits for members who are confined on the date of insolvency in skilled nursing or rehabilitation facilities if receiving covered acute care services. Plan benefits for such covered acute care services will begin on the date of insolvency and continue until the earlier of 120 days, the date of discharge, or the date covered acute care services cease.
3. For any members who are Medicaid or Title XVIII Medicare enrollees, 1 and 2 above will apply subject to the further limit that plan benefits will not extend beyond the date such member is entitled to coverage under other Title XVIII Medicare provisions or any other federal or state program.

4. Allianz Life or a carrier on its behalf will issue conversion coverage to members, without evidence of insurability, other than members who are Medicaid or Title XVIII Medicare enrollees, who apply for conversion coverage within 30 days of Plan Insolvency. The conversion coverage will be that which is customarily issued by the insurer providing coverage at its then current rates and of the type it has available for conversion.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2004, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Medical Associates Clinic Health Plan of Wisconsin
Assets
As of December 31, 2004

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	\$ 956,894	\$	\$ 956,894
Stocks:			
Common stocks	105,000		105,000
Cash and short-term investments	1,085,068		1,085,068
Investment income due and accrued	7,595		7,595
Uncollected premiums and agents' balances in the course of collection	20,288		20,288
Electronic data processing equipment and software	43,468	4,688	38,780
Receivables from parent, subsidiaries and affiliates	2,314	2,314	
Health care and other amounts receivable	412,019		412,019
Other assets nonadmitted	<u>944</u>	<u>944</u>	<u> </u>
Total assets	<u>\$2,633,590</u>	<u>\$7,946</u>	<u>\$2,625,644</u>

Medical Associates Clinic Health Plan of Wisconsin
Liabilities and Net Worth
As of December 31, 2004

Claims unpaid		\$ 156,800
Unpaid claims adjustment expenses		3,200
Premiums received in advance		70,402
General expenses due or accrued		2,218
Amounts due to parent, subsidiaries and affiliates		<u>562,344</u>
Total liabilities		794,964
Unassigned funds (surplus)	\$1,830,680	
Total capital and surplus		<u>1,830,680</u>
Total liabilities, capital and surplus		<u>\$2,625,644</u>

**Medical Associates Clinic Health Plan of Wisconsin
Statement of Revenue and Expenses
For the Year 2004**

Net premium income		\$21,184,161
Aggregate write-ins for other health care related revenues		<u>41,453</u>
Total revenues		21,225,614
Medical and hospital:		
Hospital/medical benefits	\$17,722,659	
Prescription drugs	<u>1,335,251</u>	
Subtotal	19,057,910	
Less		
Net reinsurance recoveries	<u>9,857</u>	
Total medical and hospital	19,048,053	
Claims adjustment expenses	216,718	
General administrative expenses	<u>1,670,243</u>	
Total underwriting deductions		<u>20,935,014</u>
Net underwriting gain or (loss)		290,600
Net investment gains or (losses)		<u>37,265</u>
Net income (loss)		<u>\$ 327,865</u>

**Medical Associates Clinic Health Plan of Wisconsin
Capital and Surplus Account
As of December 31, 2004**

Capital and surplus prior reporting year		\$1,475,391
Net income or (loss)	\$327,865	
Change in nonadmitted assets	<u>27,424</u>	
Net change in capital and surplus		<u>355,289</u>
Capital and surplus end of reporting year		<u>\$1,830,680</u>

**Medical Associates Clinic Health Plan of Wisconsin
Statement of Cash Flows
As of December 31, 2004**

Premiums collected net of reinsurance		\$20,872,805
Net investment income		34,196
Miscellaneous income		<u>(305,566)</u>
Total		20,601,435
Less:		
Benefit and loss-related payments	\$18,974,161	
Commissions, expenses paid and aggregate write-ins for deductions	<u>1,885,119</u>	
Total		<u>20,859,280</u>
Net cash from operations		(257,845)
Proceeds from investments sold, matured or repaid:		
Bonds	100,000	
Cost of investments acquired - long-term only:		
Bonds	\$757,922	
Stocks	<u>105,000</u>	
Total investments acquired	<u>862,922</u>	
Net cash from investments		(762,922)
Cash provided/applied:		
Other cash provided (applied)	306,556	
Net cash from financing and miscellaneous sources		<u>306,556</u>
Net change in cash and short-term investments		(714,211)
Beginning of year (cash and short-term investments)		<u>1,799,279</u>
End of year (cash and short-term investments)		<u>\$ 1,085,068</u>

Growth of Medical Associates Clinic Health Plan of Wisconsin

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2004	\$2,625,644	\$ 794,964	\$1,830,680	\$21,184,161	\$19,048,053	\$327,865
2003	2,255,628	780,237	1,475,391	20,875,361	19,036,389	7,616
2002	2,580,849	1,082,910	1,497,939	17,188,677	15,611,697	27,707
2001	2,226,446	785,795	1,440,651	14,248,148	12,901,839	10,115

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change In Enrollment
2004	1.50%	89.9%	7.9%	(6.7)%
2003	0.03	91.2	9.1	9.4
2002	0.16	90.8	9.5	9.1
2001	0.07	90.6	10.4	6.6

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2004	6,854	508.69	3.3
2003	7,346	611.53	3.7
2002	6,717	609.68	4.7
2001	6,158	524.45	4.1

Per Member Per Month Information

	2004	2003	Percentage Change
Premiums:			
Commercial	\$255.48	\$232.95	9.7%
Medicare	280.97	268.83	4.5
Expenses:			
Hospital/medical benefits	219.87	198.27	10.9
Other medical and hospital	16.56	24.79	(3.3)
Less: Net reinsurance recoveries	<u>.12</u>	<u>2.18</u>	(94.5)
Total medical and hospital	236.55	225.24	5.0
Claims adjustment expenses	2.69		N/A
General administrative expenses	<u>20.72</u>	<u>22.16</u>	(6.5)
Total underwriting deductions	<u>\$259.96</u>	<u>\$247.40</u>	5.0

In 2004, the company reported its largest net income of the three-year period under examination. The increase in net income was primarily due to rate increases, as enrollment declined approximately 6.5% from the prior year. This was the only decrease in enrollment during the period under examination. The current year net income was the most significant factor in the increase to capital and surplus of 27% over the examination period. The profit margin increased to 1.5% as both the claims expense and administrative expense ratios declined slightly over the three-year period. The average length of stay has decreased from 4.7 days in 2002, to 3.3 days in 2004.

Reconciliation of Capital and Surplus per Examination

The examination made no reclassifications and no adjustments to the company's reported capital and surplus at December 31, 2004.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were 17 specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

1. Management & Control—It is recommended that the company update their affiliated agreements to include provisions establishing performance standards, indemnification, personnel or other equipment involved.

Action—Compliance

2. Management & Control—It is recommended that the company store IT back-up tapes at a facility of adequate distance from the company to ensure their survival in the event of a disaster.

Action—Compliance

3. Management & Control—It is recommended that the company develop a formal process for reviewing IT security violations.

Action—Noncompliance

4. Management & Control—It is recommended that the company obtain conflict of interest statements on a yearly basis from all board members.

Action—Compliance

5. Management & Control—It is again recommended that the company file biographical information on its directors and officers in compliance with s. Ins 6.52, Wis. Adm. Code.

Action—Compliance

6. Management & Control—It is recommended the company file its disaster recovery plan no later than 30 days after its completion

Action—Compliance

7. Management & Control—It is recommended the company develop an overall password requirement policy which would include minimum length passwords of at least 5 characters. Passwords should expire at least every 90 days. Limits should be placed on the reuse of passwords and the numbers of incorrect login attempts before a user is locked out. It is further recommended that, where feasible, password administration should be managed by IT and not the users.

Action—Noncompliance

8. Management & Control—It is recommended the company establish a formal process for authorizing access to the Amysis system.

Action—Compliance

9. Accounts & Records—It is recommended the company report claims and liabilities as covered or uncovered in accordance with annual statement instructions.

Action—Compliance

10. Accounts & Records—It is recommended that the company calculate depreciation for EDP assets on a three-year or useful life basis and only admit 3% of total assets as EDP assets.

Action—Compliance

11. Accounts & Records—It is recommended that the company report amounts received from reinsurance contracts in the annual statement and to establish procedures to record the receipt of reinsurance recoveries.

Action—Compliance

12. Accounts & Records—It is recommended that the company use the scientific method to amortize the value of bonds as required by SSAP No. 26 of the NAIC Accounting Practices and Procedures Manual.

Action—Compliance

13. Accounts & Records—It is recommended that the company include all accrued interest on Schedule E - Part 1.

Action—Noncompliance

14. Accounts & Records—It is recommended that the company comply with ch. 177, Wis. Stat., as regards unclaimed funds, and that a liability for unclaimed funds be established in future statutory annual statements to account for all checks outstanding for over one year.

Action—Compliance

15. Accounts & Records—It is recommended the company report money market accounts as short term investments.

Action—Compliance

16. Accounts & Records—It is recommended the company disclose its repurchase agreement as required by NAIC Accounting Practices and Procedures and the NAIC Annual Statement Instructions.

Action—Compliance

17. Accounts & Records—It is recommended that the company report as unearned premium those premiums that are for a date that exceeds the valuation date.

Action—Noncompliance

Summary of Current Examination Results

This section contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the company's operations is contained in the examination work papers.

Internal Controls

The prior examination recommended that the company age its network passwords and disable network accounts after a predetermined number of incorrect attempts. During the current examination, the company indicated network passwords are not aged nor are network accounts disabled after a predetermined number of failed attempts. It is again recommended that the company age its network passwords and disable network accounts after a predetermined number of incorrect attempts.

The prior examination recommended that the company establish a formal policy for reviewing security violations. The current examination identified that the security event logging for AMISYS was turned off as it created a performance issue, although logging could be turned on if necessary. The examination also identified that security violations were not being proactively monitored, as the company determined monitoring to be a privacy issue for the users. However, monitoring unauthorized access attempts to accounts or computer resources improves the security over computer resources as it can identify issues before they occur. This is especially relevant to the company as there is no limit on attempts to access the company's network as noted above. It is again recommended that the company establish a formal policy for reviewing security violations.

Management and Control

It was noted in the review of the board minutes that the board is not approving investments. The investment committee has developed a checklist regarding the company's investment policy, which is used to determine if investments made by the custodian/advisor meet company policy. The investment committee has authority over investments, but per company policy they have delegated authority to select investments to their custodian/advisor. Thus, although investing activity is transacted according to board-approved policy, the board does not

formally approve investments. It is recommended that the company amend its investment policy to specifically include board approval of investments and that the board approves all investments.

A directive issued by the Commissioner of Insurance requires companies to implement and enforce a procedure under which all directors and key officers complete a conflict of interest statement annually, to disclose any material interest or affiliation which is likely to conflict with their official duties. The company was not able to provide conflict of interest statements for key officers who were not board members. A recommendation was made in the prior examination regarding this item; however, the recommendation only referred to board members. The company did comply with the recommendation as all board members completed a conflict of interest statement for the years under examination. It is recommended that the company implement and enforce a procedure under which all directors and key officers complete a conflict of interest statement annually and that such statements be maintained for review.

The board of directors was composed of 7 directors in 2002 and 9 directors in 2003 and 2004. At the April 4, 2005, board meeting, the board elected an additional director for a total of 10 directors. The company's bylaws state that the board may be composed of up to 11 directors, but the number of directors shall always be an odd number. It is recommended that the number and composition of the board of directors conform with Article Two, Section Two, of the company's bylaws or that the bylaws be amended to reflect current practice.

Investments

The company restructured its portfolio in December of 2004 to consolidate its investments with Dubuque Bank & Trust. Review of the company's current custodial agreement noted that it is substantially more narrow in scope than the recommended language of the NAIC's Financial Condition Examiners Handbook as follows:

The custodian is obligated to indemnify the insurance company for any insurance company's loss of securities in the custodian's custody; and
In the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced.

It is recommended that the company amend its custodial agreement to contain the proper indemnifying language as contained in the NAIC's Financial Condition Examiners Handbook.

It was determined in the review of Investment Income Due and Accrued that an immaterial amount of accrued interest was not reported on Schedule E-Part 1 of the Annual Statement. The examination also noted several other minor errors in the completion of Schedule D-Part 1 of the Annual Statement and nothing was reported on Schedule E-Part 3, Special Deposits. The company should be reporting any deposits held by the state on this schedule. It is again recommended that the company properly include all accrued interest on Schedule E-Part 1 of the Annual Statement, and further recommended that the company properly complete Schedule D and all investment-related schedules in accordance with the NAIC's Annual Statement Instructions–Health.

Premium

The prior examination recommended that the company report as unearned premium those premiums that are for a date that exceeds the valuation date. The recommendation was referring to quarterly reporting of unearned premium. The HMO correctly reported as advance premium December cash receipts for those contracts with effective dates subsequent to year-end. However, it was determined that the company continued to report the unearned portion of those premiums as advance premium on successive quarterly statements. It is again recommended that the company report as unearned premium those premiums that are for a date that exceeds the valuation date in accordance with the NAIC's Annual Statement Instructions–Health, and the NAIC's Accounting Practices and Procedures Manual SSAP No. 54.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The company's calculation as of December 31, 2004, as modified for examination adjustments is as follows:

Assets	\$2,625,644	
Less:		
Special deposit	175,000	
Liabilities	794,964	
Examination adjustments	<u>0</u>	
Total		\$1,655,680
Net premium earned	21,184,161	
Compulsory factor	3%	
Compulsory surplus		<u>635,525</u>
Compulsory Excess		<u>\$1,020,155</u>

VIII. CONCLUSION

Medical Associates Clinic Health Plan of Wisconsin is a nonprofit group model health maintenance organization insurer. The company contracts with its sponsoring clinic, Medical Associates Clinic, P.C., to provide primary and specialist services to its members.

During the period under examination, assets increased 18% to \$2.6 million and capital and surplus increased 27% to \$1.8 million, even though enrollment decreased 6.7% over the past year. Operations for 2004 produced net income of \$327,865, the highest in the three-year period.

The examination determined company compliance with 13 of the 17 prior examination recommendations. The current examination resulted in 8 recommendations, 4 of which were repeated from the prior examination. These are summarized in the "Summary of Comments and Recommendations" section of this report. There were no reclassifications or adjustments to surplus as a result of the examination.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 25 - Internal Controls—It is again recommended that the company age its network passwords and disable network accounts after a predetermined number of incorrect attempts.
2. Page 25 - Internal Controls—It is again recommended that the company establish a formal policy for reviewing security violations.
3. Page 26 - Management and Control—It is recommended that the company amend its investment policy to specifically include board approval of investments and that the board approves all investments.
4. Page 26 - Management and Control—It is recommended that the company implement and enforce a procedure under which all directors and key officers complete a conflict of interest statement annually and that such statements be maintained for review.
5. Page 26 - Management and Control—It is recommended that the number and composition of the board of directors conform with Article Two, Section Two, of the company's bylaws or that the bylaws be amended to reflect current practice.
6. Page 27 - Investments—It is recommended that the company amend its custodial agreement to contain the proper indemnifying language as contained in the NAIC's Financial Condition Examiners Handbook.
7. Page 27 - Investments—It is again recommended that the company properly include all accrued interest on Schedule E-Part 1 of the Annual Statement, and further recommended that the company properly complete Schedule D and all investment-related schedules in accordance with the NAIC's Annual Statement Instructions—Health.
8. Page 27 - Premium—It is again recommended that the company report as unearned premium those premiums that are for a date that exceeds the valuation date in accordance with the NAIC's Annual Statement Instructions—Health, and the NAIC's Accounting Practices and Procedures Manual SSAP No. 54.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
DuWayne Kottwitz	Insurance Financial Examiner
Randy Milquet	EDP Specialist

Respectfully submitted,

Jean Suchomel
Examiner-in-Charge